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ABSTRACT

This report, based on a national interdisciplinary conference, provides a historical perspective as well as a review of recent research on the topic of public drunkenness. The materials look at the problem from the perspective of the community, health care providers, and the criminal justice field. Legal issues are discussed, especially the Uniform Alcoholism and Intoxication Treatment Act, and a full range of treatment alternatives are provided. The "Action Agenda" developed by conference participants is highlighted. The conflicting goals in decriminalizing public intoxication are discussed along with the status of decriminalization legislation in various states. The appendices contain a list of conference speakers and participants, information on the status of the Uniform Act in states that have not enacted it, a state-by-state list of uniform act implementation grants, addresses of public inebriate programs mentioned in the report, and descriptions of conference-sponsoring organizations. (JAC)

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The Public Inebriate
Overview and Alternatives to Jail

A report from the First National Conference on the Public Inebriate
July 14-16, 1980

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We have been repeatedly arrested . . . and when we could not be coerced into pleading guilty to the alleged crime (of public drunkenness) . . . [we] were forced to stay in jail thirty days or more . . . exploited as slave labor within numerous jail facilities . . . at huge expense to the deceived taxpayers forced to support this barbarous practice.

—from the petition for writ of Habeus Corpus to Central District Court of California, 2/6/75; by and on behalf of Robert Sundance (et al), public inebriate, incarcerated an average of fifty times each year by California authorities

There are no marches on Washington on public drunkenness . . . the public inebriate has no national constituency . . . doesn't vote, pay taxes, or lobby. But there are people in this country who care; who have been active in this area for years. We have brought some of you together here . . . to create a bandwagon for change.

—from the opening remarks at the First National Conference on the Public Inebriate; by Judith Johnson, Executive Director, National Coalition for Jail Reform; at Wingspread, Racine, Wisconsin, 7/14/80

Preface

Shortly after the National Coalition for Jail Reform was formally established in May of 1978, it adopted as its first policy position that, "public inebriates should not be subject to criminal prosecution or jail confinement because of their consumption of alcoholic beverages."

The issue had major implications, involving over a million arrests each year and millions of dollars in misdirected public resources. Beyond the need to find solutions to the problem, there was also considerable optimism that a national campaign to remove public inebriates from jail would attract widespread public support. The plank, after all, was consistent with the findings of three Presidential Commissions, the legislative directives of more than 30 states, and the policies of such prestigious organizations as the American Bar Association, the American Medical Association, and the World Health Organization, to name a few.

The Coalition assumed that considerable reform efforts were already in progress, but this perception rapidly changed. Instead of climbing on a national reform bandwagon, as was anticipated, the Coalition soon found itself in the driver's seat. It quickly became apparent that there was no organized national constituency working at implementing decriminalization legislation or establishing the alternatives that would make decriminalization a reality. The problem appeared to be a low priority for federal, state, and local governments, as well as for many segments of the professional alcholism community.

The Coalition could uncover only one national meeting on the public inebriate, held seven years earlier (May 1973), involving a small group of scholars. To date, no national study has been conducted to evaluate state/local efforts in decriminalization, nor has a national analysis been conducted to compare the costs of a health and social service approach to the costs of the criminal justice approach—arresting, booking and jailing—in handling the public inebriate.

Although 34 states, territories, and the District of Columbia, have to a substantial degree, adopted the Uniform Alcoholism and Intoxication Treatment Act, it is now obvious that even in these states drunken people are still being arrested—often on other charges, such as disorderly conduct or disturbing the peace.

Thus, it was against this background of hope and false expectations that the Coalition joined forces with the National Council on Alcoholism and the National Association of State Alcohol and Drug Abuse Directors, to co-sponsor this first national interdisciplinary conference on the subject of public drunkenness.

The sixty participants at the conference represented a wide cross section of elected state and local officials, major constituent organizations, the legal and law enforcement community, researchers and local alcohol professionals. Everyone who is involved in the problem, it was felt, must be involved in the solution.

The goals of the meeting were to provide a national assessment of the problem; to educate the public on the magnitude of the problem; to reach consensus on appropriate alternatives; and to develop an action agenda for coordinated national organizational involvement.

Although this report references the key discussions and recommendations of the conference, it is more a synthesis than a faithful record of the proceedings. Much additional information has been included to provide the reader with an historical perspective, the benefits of recent research and information, and the reflective insights and perceptions of the participants gleaned in the aftermath of the conference itself. The conference agenda, panelists, and participants are listed in the appendix.

This report first looks at the problem from three perspectives: that of the community, of the health care providers, and of the criminal justice field. After a discussion of historical and legal issues, a full range of treatment alternatives is presented. Last, the "action agenda" developed by conference participants is highlighted. The materials in this document are a synthesis of the views of the conference—participants plus other background materials—and do not necessarily reflect the views of any one individual or sponsoring organization.

Little is known about public inebriates and even less about women who are arrested for being intoxicated in public. Research that has been done indicates that the public inebriate population is predominantly male. In a survey of State Alcohol Directors, 90% of the public inebriates in the states were identified as males, and in a New York State study only 5–20% of those arrested for public

intoxication were women. Similarly more programs are available for intoxicated males than females, although, it is important to note that data on most of those described in this report apply to both men and women.

Because of the apparently larger numbers of publicly intoxicated males and programs for them, this report uses the word "he" to refer to the public inebriate. However, we are cognizant of the fact that there are many female public inebriates and we strongly advocate more research on the profile of women inebriates and their needs for care and/or treatment.

The sponsoring organizations are deeply grateful to the Johnson Foundation for hosting this historic meeting. Richard Kinch, Program Associate at the Foundation, provided invaluable assistance and advice on both the content and format of the program. Kay Mauer, the Foundation's Conference Coordinator, kept track of the endless arrangement details that decide the quality of such an undertaking. To both, and to an outstanding group of participants, we express our gratitude for making this meeting such a stimulating and productive experience.

We are also indebted to the Wisconsin State Bureau of Alcohol and Other Drug Abuse for its financial support of these proceedings. An early draft of these proceedings was prepared by Margo Redmond; Richard Yoast and the Wisconsin Clearinghouse prepared the format and layout of the final publication.

The writers are particularly grateful to Sheila Blume, Director, New York Division of Alcoholism and Abuse, for her extensive review of an early draft of this report. Finally, we also wish to thank Phyllis Oresky, Administrative Assistant, National Coalition for Jail Reform, who so ably dealt with the conference arrangements and many drafts of the proceedings.

- **Judith Johnson,** *Executive Director*
  National Coalition for Jail Reform
- **Mark Fontaine,** *Program Manager*
  National Association of State Alcohol
  and Drug Abuse Directors
- **Donald Murray,** *Chairman*
  Public Inebriate Committee
  National Coalition for Jail Reform
- **Diana Tabler,** *Director*
  Office of Public Policy
  National Council on Alcoholism

What is the Problem?

The problem of public inebriacy is extensive and multifaceted. It is a problem to the community, the health care system, and the criminal justice system. Before describing these different aspects of the problem, it is important to clafiry what is public inebriacy and who is the public inebriate.

In the broadest sense, a public inebriate is anyone found intoxicated in public. This includes, among others, young people who drink too much and become rowdy; working people who are celebrating the weekend and drink too much; and the group this report focuses on—the chronic skid row alcoholic. For the purpose of this conference and this report, the following definition was used:

A public inebriate—one who is repeatedly drunk in public, has frequent contact with the police, often resulting in incarceration and has limited financial and other resources.

For example, Dewitt Driver, an alcoholic, was arrested over 200 times for public intoxication. He spent two-thirds of his adult life in jail on charges of public intoxication.

Robert Sundance and two other men were arrested a total of 645 times in ten years. During the decade from 1964–1974, the three men spent over 16 years in jail for public intoxication. During the three years from 1972–1975, Mr. Sundance and the other two men entered 64 "not guilty" pleas and, though never brought to trial, were held in jail 1,419 days before their cases were dismissed. They were in jail a third of the time during these three years and were never offered any alcohol treatment.

Public inebriates are usually alcoholics who have no job, no home, no family. They have few skills or personal resources and drift about the city panhandling or working temporarily as laborers. They often have serious medical and nutritional problems. They sleep in doorways, subways and abandoned buildings. They eat at soup kitchens or scavenge from trash barrels. And often, they come in contact with the police.

The profile of the public inebriate varies from one area of the country to another and from large cities to small towns, but downtrodden, homeless, jobless alcoholics can and do exist everywhere; though they are less likely to be found in small towns or suburbs than in big cities. Profile data collected from state alcohol directors suggests that in cities, the public inebriate is typically a 45-year-old white male, unemployed, with nine years of education, divorced or never married, homeless, receives no public

assistance and has a long history of arrests for public drunkenness. But this profile may be changing. The average age seems to be dropping from those in their forties to include many people in their thirties. In the West, many public inebriates are Native Americans and Mexican Americans.

Public inebriates are always in danger of arrest, and once arrested, face an impossible choice, as described by Timothy Flynn, the lawyer for Robert Sundance.

After doing time in a lockup an alcoholic is on the edge of withdrawal. It becomes a 'Hobson's choice.' The drunk is in pain. If he pleads 'not guilty' he will be kept 30 days awaiting trial. He knows that means 30 days of agony. If, on the other hand, he pleads 'guilty,' he knows the police will let him out in three days. When he gets back on the street his fear of this excruciating pain drives him to drink, and the police come around and pick him up again.

From the community's viewpoint, the public inebriate is a blight, an eyesore, a nuisance. Business owners do not want drunken people lying on their doorsteps, and the public does not want public drunks sprawled over park benches. Urban renewal has exacerbated the problem. When cities are renovated, the places where homeless public inebriates congregate are cleaned up, pushing them into other areas of the city, such as downtown business areas.

In rural areas, the problem is even more difficult. Ray Daugherty, Executive Director of the Kentucky Alcoholism Council, points out that up to sixty percent of the arrests in Kentucky's rural areas are still for public drunkenness. In a small community, the public drunk is both more isolated and more visible than in urban areas. The problem is compounded by the fact that treatment resources are more limited.

On the health care side, the public inebriate is neglected. Many services to the average alcoholic do not reach this population. Hospitals do not welcome this group nor reach out to provide detoxification services for people without insurance. Treatment programs are often leery of dealing with the chronic homeless alcoholic because they are a difficult population to work with and "success" is difficult to obtain. The public inebriate is often not included in the continuum of care provided by the treatment system to other alcoholics. In short, the alcohol treatment field is reluctant to expend its limited resources on what they see as a difficult group to help.

In addition to the drinking problem, the public inebriate has serious medical and nutritional problems. A study of 3,145 admissions to the Manhattan Bowery Project, a treatment program for public inebriates, found that 20% had fractures, 50% had wounds, cuts or burns, 20% had hallucinations, 20% suffered from severe brain damage, 20% had severe gastro-intestinal bleeding, 15% had cardio-pulmonary problems, and 25% had indications of seizure disorder. It is expensive to deal with these conditions, and the public inebriate usually does not have health insurance or even social security coverage to pay for needed medical treatment.

The plight of the public inebriate is further complicated by the presence of psychiatric problems. The Manhattan Bowery Project found that 34% of the clients they detoxified had psychiatric illnesses. The New York City Men's Shelter found 48% of the men to have pronounced psychiatric problems. The problem of the multiply-disabled population, with both alcohol and psychiatric problems, is a new and difficult one for health care agencies. Alcohol agencies traditionally have been geared to the needs of the alcoholic, who is otherwise free of mental illness. Neither the mental health nor alcohol agencies are geared to serve this multiply-disabled popluation.

For the criminal justice system, the public inebriate presents many problems. Judges get frustrated with seeing the same people again and again, and don't know what to do to help them. The lack of alternatives and resources for public inebriates forces the police to either leave them on the streets or arrest them and take them to jail. Police don't like to spend their time acting as social service agencies or as transportation systems. They too are frustrated at dealing with the same people again and again. The public inebriate in the criminal justice system uses up a large part of a community's resources which should be allocated for handling serious criminal justice offenders. Jails do not have the staff to handle the medical and social problems of the public inebriate.

In 1979, according to the FBI's Uniform Crime Reports, there were over a million arrests for "drunkenness." In Kentucky, 33% of all arrests are for public drunkenness, and in Utah, 25–33% of the jail population are there as a result of a public intoxication charge. One out of every three arrests in the country is for public drunkenness or disorderly conduct.

Even in the 34 states and territories which have decriminalized public intoxication, the police continue to be responsible for intoxicated people when there are no alternatives to jail. If the police can no longer charge them with public drunkenness and have nowhere else to take public inebriates, then arrests on other charges, such as disorderly conduct, will occur. In Minneapolis from 1960–1966, the yearly average for disorderly conduct arrests was 697. After public intoxication was decriminalized in 1971, the yearly average for disorderly conduct arrests rose to 1,975, according to David Aaronson, Professor of Law, American University.

New Mexico has decriminalized public intoxication but has included a statute which allows inebriates to be jailed for "protective custody." Gallup, New Mexico, a city of 18,000, is a magnet for the surrounding areas, and last year, according to *Corrections Magazine*, Gallup booked 26,000 drunken people into jail for "protective custody," many of whom were American Indians. The Gallup drunk tank is a 4,800 square foot cell with no beds or mattresses and the jail has no alcohol treatment program. The same people go through the drunk tank again and again.

Aaronson reports that in Boston, the year before decriminalization, 12,627 people were arrested for public drunkenness. When arresting for public intoxication was no longer possible and few alternatives to jails had been developed by the community, 8,755 people were taken into "protective custody" and held in jail for 12 hours to dry out.

Decriminalization does not always lead to arrests on other charges, and this varies from state to state. In fact, Sheila Blume, Director of the New York Division of Alcoholism, reported that, "There is some evidence that a large proportion of public inebriates in New York are finding their way into the alcoholism service system, rather than simply being arrested on other charges."

Jails are designed to hold people awaiting trial and those serving short-term sentences. They are not built to meet the medical and mental health needs of homeless chronic alcoholics.

Public inebriates run a high risk of suicide in jail. Dr. Page Hudson, Chief Medical Examiner of North Carolina, reported that in a study he did of deaths in North Carolina jails from 1972–1976, one-third of the deaths were suicides. More than half of these suicides took place during the first 12 hours in jail, and eighty-five percent of the people who committed suicide were intoxicated. One half of those who died during the first 24 hours after arrest were intoxicated at the time of death. It is estimated that intoxicated people make up over half of those in jail in North Carolina.

When an alcoholic is going through withdrawal symptoms, he is frightened and in extreme pain—at risk for such endangering events as seizures, liver failure and delirium tremors (D.T.'s). Most jails are not able to provide the supportive environment, medical attention, and helping atmosphere so critical to the care of alcoholics during withdrawal.

Jail staff are not trained to identify despondent life—threatening behavior or to distinguish between the slurred speech and unsteady gait of someone who is drunk and someone who has a cerebral hemorrhage. Police do not routinely take intoxicated people to hospitals as they do others with obvious physical problems. Alcoholics are not considered "really" sick.

Holding public inebriates in jail is very expensive. It costs $25,000–$60,000 to build each jail cell and $7,000–$26,000 a year to maintain each person in jail. And jails provide few services —half of the jails have no medical facilities and only a third provide any alcohol services.

Public inebriates are a problem for everyone—the community, businesses, alcohol and medical program staff, police and jailers. The public reacts negatively to the public inebriate in the parks and in the doorways of businesses. Health care programs and alcohol professionals are overwhelmed by this multiply-disabled population. Police, sheriffs and jail staffs have had no choice but to deal with the problem that the rest of the community neglects.

History

In the mid 1950's, the World Health Organization and the American Medical Association stated that alcoholism was a disease and should be treated as a medical problem. This acceptance of alcoholism as a treatable disease has brought about rapid growth in the number of public and private alcohol treatment agencies and the removal of criminal penalties for public intoxication. Further changes in society's view of the public inebriate took place in the 1960's as a result of three important court decisions; the recommendations of governmental and private commissions; and finally, legislative reform.

Court Decisions

Public intoxication was a criminal offense in all jurisdictions of the United States until 1966. In 1966, in the first of several landmark decisions, the District of Columbia Circuit of the U.S. Court of Appeals, in the case of *Easter v. District of Columbia*, held that because alcoholism is a disease an alcoholic was not in control of his drinking behavior and therefore could not be punished for public intoxication. In the same year, the U.S. Court of Appeals for the Fourth Circuit ruled, in *Driver v. Hinnant*, that conviction of a homeless alcoholic for public intoxication constituted "cruel and unusual punishment" in violation of the Eighth Amendment to the U.S. Constitution. These court decisions reflected a growing public belief that alcoholism should be treated as an illness.

In 1968, in the case of *Powell v. Texas*, the U.S. Supreme Court narrowly upheld the conviction of a public inebriate who had a substantial arrest record for public drunkenness. The court declined to extend the ruling of *Easter v. District of Columbia* and *Driver v. Hinnant* to include an alcoholic who has a home and family. More important, however, a majority of the court indicated that punishment of a homeless alcoholic for public intoxication would violate his or her Eighth Amendment rights *and* that alcoholism is a disease, with involuntary drinking a symptom of that disease. The Powell decision also reflected a unanimous recognition that current facilities, procedures and legislative responses to the problem of the public inebriate had been inadequate.

Commission Recommendations

In 1967, three authoritative commissions—the United States and District of Columbia Crime Commissions and the Cooperative Commission on the Study of Alcoholism—all found that the criminal law was an "ineffective, inhumane and costly device" for the prevention and control of alcoholism, including public drunkenness. All recommended that a public health approach be substituted for criminal procedures. In 1969 the American Bar Association and the American Medical Association released a "Joint Statement of Principles Concerning Alcoholism" in which they urged state governments to adopt legislation in which alcoholism would be viewed as an illness, and public intoxication would no longer be handled as a criminal offense. The first jurisdiction to decriminalize intoxication was the District of Columbia, where Congress enacted the "District of Columbia Alcoholism Rehabilitation Act" in 1968 (Public Law 90–452).

Legislation

The growing awareness of the problem of alcoholism in society and concern for the need to treat alcoholics ultimately led to Federal legislative reform. In 1968 Congress passed the "Alcoholic Rehabilitation Act" (Public Law 90–574), the first law dealing with the treatment of alcoholism on a national basis. The problem of the Public Inebriate was one issue the Congress addressed through the act:

The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcoholism, whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.

In 1970 this initiative was greatly expanded with the enactment of the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970" (Public Law 91-616). This legislation established, for the first time, a major public health care demonstration project to assist states, local governments and communities to identify and address the needs of alcoholics. It also included the establishment of the National Institute on Alcohol Abuse and Alcoholism (NIAAA), to administer a program of treatment, prevention and research efforts on alcoholism. Individual grants were authorized to states and communities to plan and carry out comprehensive alcoholism treatment programs, including a number of projects especially designed for the public inebriate. As with projects for other populations, Congress intended these grants to be demonstration projects, not a long-term entitlement service. In 1981, twenty-one Public Inebriate Programs in fifteen states were receiving support from the Federal Government through NIAAA.

The Uniform Alcoholism and Intoxication Treatment Act

The model act states:

Section 1. It is the policy of this State that alcoholics and intoxicated persons may not be subjected to criminal prosecution because of their consumption of alcoholic beverages, but rather should be afforded a continuum of treatment in order that they may lead normal lives as productive members of society.

To enhance the federal legislative initiative carried out through the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act, a "Uniform Alcoholism and Intoxication Treatment Act" was designed in 1973 by the National Conference of Commissioners on Uniform State Laws. The purpose was to assist states in developing public health approaches and treatment systems similar to the federal model, incorporating the principle of removing criminal penalties for alcohol intoxication. The model act outlined a legal framework which a state could use to create a public program of care for the alcoholic. The essential elements of the Uniform Act are:

★ Adoption of a policy that alcoholism is an illness, and removal of all criminal penalties for intoxication;

★ Establishment of a comprehensive "continuum of care" treatment system which includes a broad range of necessary services, (such as emergency treatment, inpatient, intermediate and outpatient care, and follow-up) as well as standards for treatment facilities;

★ Establishment of a state administrative structure for planning and carrying out the treatment system;

★ Enactment of state laws which allow treatment of an alcoholic patient on a voluntary basis, and which do not deny an alcoholic treatment simply on the basis of his or her previous withdrawal from treatment against medical advice or because of a relapse from previous treatment; and

★ Enactment of laws governing the involuntary commitment (for up to 48 hours) of an alcoholic to a public treatment agency which protect both the individual and the community.

In an effort to encourage states to adopt this policy toward the care of the alcoholic, Congress authorized special grants to states which adopted the model act or a version similar to it. These "Special Grants for Implementation of the Uniform Alcoholism and Intoxication Treatment Act" were added to the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 in amendments contained in Public Law 93-282. This section was later redesignated Section 310 of the statute by Public Law 94-371. In doing this, Congress authorized a special grant to qualifying states not to exceed $150,000 plus an amount equal to twenty percent of the allotment a state had received under the "State Formula Grant" authority of Public Law 91-616. These grants were slated to assist states in meeting the costs of implementing the Uniform Act, and were limited to a total of six years per state.

Funds were first appropriated for Uniform Act grants to states in 1975 and sixteen grants were awarded that year. By fiscal year 1980, a total of 34 states or territories, including the District of Columbia, Puerto Rico and the Virgin Islands, have passed the Uniform Act legislation and have qualified for incentive grants totalling $11 million. A chart showing a state-by-state funding history is included in the Appendix.

The following table provided by NIAAA lists states that have Uniform Act legislation as well as the Uniform Act grants, and the dates the funds were provided:

STATE	EFFECTIVE DATE	STATE	EFFECTIVE DATE
1. Alaska	10/9/72	18. Nevada	7/1/75
2. Arizona	8/13/72	19. New Hampshire	6/23/79
3. Colorado	7/1/74	20. New Jersey	5/9/77
4. Connecticut	6/1/76	21. New York	1/1/76
5. Delaware	7/16/79	22. North Carolina	10/1/78
6. Dist. of Columbia	8/3/67	23. North Dakota	7/7/71
7. Florida	7/1/73	24. Oregon	7/1/72
8. Hawaii	5/20/76	25. Rhode Island	5/2/72
9. Idaho	1/1/77	26. South Dakota	7/1/74
10. Illinois	7/1/76	27. Washington	1/1/75
11. Kansas	7/1/77	28. Wisconsin	8/1/74
12. Maine	7/1/74	29. Puerto Rico	7/22/74
13. Maryland	7/1/68	30. Michigan	11/15/78
14. Massachusetts	7/1/73	31. Missouri	7/1/78
15. Minnesota	7/1/71	32. New Mexico	7/1/78
16. Massachusetts	7/1/75	33. Vermont	7/1/78
17. Nebraska	1/1/79	34. Virgin Islands	7/1/79

Two states—Georgia and Kentucky—have enacted the Uniform Act or similar legislation effective July 1, 1981, and are eligible for incentive funding in fiscal year 1981.

Information on the status of Uniform Act legislation in those states which have not yet passed the Act and qualified for incentive funding is included in the Appendix.

Enactment of the Comprehensive Alcohol Abuse and Alcoholism Prevent, Treatment and Rehabilitation Act of 1970 by the Federal Government, accompanied by the development of state-based alcoholism treatment programs, has made a tremendous impact on the availability and quality of public and private services for the average alcoholic and his or her family. According to a 1979 National Alcohol and Drug Abuse Treatment Utilization survey, nearly $800 million is being spent annually by public and private sources on treatment services alone. What is not known, however, is the extent to which the public inebriate has been affected by these programs.

Decriminalization of public intoxication is central to addressing the health care needs of the public inebriate. But decriminalization alone is no cure for these complex health and social problems. Donald J. McConnell, Executive Director of the Connecticut Alcohol and Drug Abuse Council, cited certain problems that arose in that state immediately following enactment of the Uniform Act in 1974.

The alcoholism field has been less concerned with the public inebriate as a person than with eradicating the stigma of alcoholism in the public's mind.

—John R. DeLuca, Director of NIAAA

Prior to passage of the law, alcoholism counselors in Connecticut routinely checked the jails to observe drunken prisoners and determine if medical attention was needed. Following passage of the Act, however, McConnell noted that police and others in the community acted as if inebriates were no longer in the jails. As a result of failure by the police to check for indications of intoxica-

tion among certain vagrant and disorderly arrests, several individuals developed delirium tremors, resulting in physical harm. As a result of this experience, McConnell concluded that passage of decriminalization legislation can result in a "false sense of security" within the community and in the jails. The treatment system will have to take on new responsibilities to ensure that these people are helped.

The Future of Decriminalization and the Uniform Act

The National Conference of Commissioners on Uniform State Laws drafted the model Uniform Alcoholism and Intoxication Treatment Act. John McCabe of the National Conference points out that "just as the Uniform Act grew out of needs perceived at the time of its drafting, it is still growing, and evolving. . . . Ten years from today, a progressive Uniform Act to decriminalize intoxication might bear little resemblance to today's law."

At issue in the care of the public inebriate are not only the immediate problems which result in attempts to coordinate two disparate systems—health and criminal justice—but also the impact of current political and economic realities, according to McCabe. For example, the recession of 1973 and 1974 resulted in diminished legislative activity at the state level. Unemployment and revenue shortfalls create situations within which states are less inclined to expand social and health programs, particularly for as "undesirable" a lot as the public inebriate. Continuing trends of this type may lessen public concern for the public inebriate, and thus, there may be fewer states decriminalizing public intoxication.

Twenty states or territories adopted the model Uniform Act and another 14 adopted some variation of it. Many of the states which have yet to enact the law are working first on establishing treatment facilities before undertaking the more controversial decriminalization. The strategies have changed from focusing on decriminalization to focusing on alternative treatment facilities and support services in order to implement the decarceration principle with or without the formal legislative action.

The issue of "protective custody" is still being debated. Police like to have this clause in the law, a step down from involuntary commitment provisions, to allow them to keep the streets clear of public inebriates. There is a tension between this view and those who feel coercive treatment or "protection" is unworkable and hence, unacceptable. With the swing in public policy away from institutionalizing people, McCabe said, there is less interest in long-term involuntary commitment for public inebriates.

Just when we are becoming effective at intervention, the money for adequate treatment is drying up.

—Larry Monson, Wisconsin Bureau of Alcohol and Other Drug Abuse

Recent Legal Activities

A recent case in California, a state which has not decriminalized public intoxication, has renewed legal interest in the problem of the public inebriate. The case, *Sundance v. Municipal Court of Los Angeles*, has added a new perspective to the issue of society's negligence and lack of success with regard to the public inebriate.

As mentioned earlier, Robert Sundance was a 50-year-old public inebriate who averaged over 50 public drunkenness arrests per year and spent 200–300 days during the decade 1965–1975 in the Los Angeles County Jail system solely as a result of these arrests. Sundance had written over 80 handwritten requests for habeus corpus during the same decade; all but one of which were denied. The last of these was finally referred by a Federal District judge to the Center for Law in the Public Interest. Center attorney Timothy Flynn began researching the case, and only chose to pursue a civil rights class action and taxpayer suit after Governor Brown in 1975 vetoed decriminalization legislation as well as the $22 million set aside by the California legislature for alcoholism treatment funding. When the case was filed in 1975, the city of Los Angeles had over 10,000 public inebriates, and city police alone were making 55,000 arrests for public drunkenness annually. Approximately 1,000 homeless alcoholics accounted for most of these arrests. As a result of so many arrests and virtually no trials, police often neglected to fill out the routine arrest report or otherwise collect and preserve evidence of the "alleged crime."

The class action suit, filed on behalf of Robert Sundance, four other inebriates, and one taxpayer, represented the public inebriate population of downtown Los Angeles. The trial took eight weeks and was based on massive medical and statistical evidence that incarceration of chronic homeless alcoholics violated the Eighth Amendment prohibition against cruel and unusual punishment as established in the *Easter*, *Driver* and *Powell* cases, and resulted in shocking and systematic abridgement of basic due process and equal protection guarantees under the Fourteenth

Amendment. A landmark decision resulted, based on four conclusions reached by the Los Angeles Superior Court:

★ The court agreed that conviction and imprisonment of homeless alcoholics for public drunkenness is in fact cruel and unusual punishment and recognized a constitutional defense to the charge;

★ The court also held that "due process" was denied systematically because the state had no intention of bringing these individuals to trial (most of the public intoxication cases were dismissed immediately prior to trial "in the interest of justice" after the individuals were detained up to 30 days awaiting trial); public inebriates with severely impaired judgment were routinely pleading guilty at arraignment without required admonitions of waivers of constitutional rights and without counsel;

★ The court concluded that such processing of public inebriates by the Los Angeles justice system was in fact a tragic waste of taxpayers' money ($7.4 million in 1976 alone), but that implementation of the policy changes needed for diversion was a matter for legislative action;

★ Finally, the court said that medical screening and monitoring is required for any alcoholic incarcerated on public drunkenness charges.

These judicial decisions have had a significant impact on how public inebriate cases are now handled in Los Angeles. Prosecutions have declined by 92 percent in the two years since the case was decided and jail administrators are more aware of their responsibility to provide adequate and necessary medical attention to alcoholics. In addition, public inebriates are no longer targets for routine police action. Law enforcement personnel in Los Angeles have also become the best political proponents for public inebriate diversion facilities and enabling legislation.

This case has several implications for the issue of decriminalization of public drunkenness. First, it resurfaces the issue of the legality of criminal penalties for public drunkenness, an issue that has been dormant for eight years. Secondly, it raises the spector of systematic violation of the Eighth Amendment by suggesting that unless adequate medical screening or intake and monitoring throughout the period of detoxification and withdrawal is provided, detention of a public inebriate solely to sober up in jail would be considered cruel and unusual punishment. And, finally, it offers the use of lawsuits as vehicles to eliminate criminal justice sanctions against chronic alcoholics who are habitually drunk in public.

Other legal developments that may be important to the future care of public inebriates were pointed out by Timothy Flynn of the Center for Law in the Public Interest and Don Murray of the National Association of Counties. They reported that two Supreme Court cases, *Monell v. the City of New York Department of Social Services* and *Owen v. City of Independence*, though not themselves public inebriate cases, had dramatically increased the exposure of local governments to civil suits seeking money damages for alleged violations of constitutional rights under Section 1983 of the Civil Rights Act of 1871. Section 1983 prohibits "persons" acting under the color of state law from violating rights secured by federal law.

The Act has been the main federal statute authorizing redress to citizens whose rights have been allegedly violated by government action. Before the *Monell* decision, court decisions were limited to monetary damages against the government employee who committed the act in question (police officers, administrators, etc.), and were not permitted against the public agency itself.

Until the 1978 *Monell* decision, local governments themselves were totally immune from liability under 1983. The *Monell* case, however, held a local government would be a "person" under the Act and thus, they were no longer entitled to absolute immunity. In 1980 in another landmark case, *Owen v. City of Independence*, the Supreme Court expanded governmental liability even further by holding that local governments could not assert "good faith" as a defense in 1983 cases.

Flynn and Murray suggested that this expanded interpretation of 1983 could eventually end the practice of jailing public inebriates, since most jails lack the resources to provide adequate facilities and services for alcoholics and leave local governments extremely vulnerable to liability for massive damage claims. Thus, even in the absence of a Supreme Court decision holding the jailing of public inebriates to be unconstitutional—monetary judgments might very well make such practices financially unrealistic. Attorney's fees are also authorized in cases under 1983 by the Civil Rights Attorney's Fees Awards Act of 1976.

Decriminalization of public intoxication was the first step. But simply enacting legislation such as the Uniform Act is not enough. Until we develop programs that meet the needs of the community, and the public inebriate, nothing much will have changed.

The System of Care

What programs, facilities, and treatment services are needed for the public inebriate? The ideal system of care for public inebriates would include several elements. This continuum must provide everything needed to bring a person to full recovery, or stabilization at the highest possible level of functioning. For the public inebriate, this means more than detoxification or traditional treatment services. An ideal system of care would include:

- Transportation services
- Shelters/reception centers
- Detoxification services
- Extended care
- Domiciliary care
- Housing, support and job training

Transportation

Good transportation services are essential to an effective system of care. Unless a means is available to transport clients to the necessary facilities, the beds and services will not be utilized.

Community service patrols have been initiated in many communities. Usually these are vans that patrol the skid row area to pick up public inebriates. Staff for these vans are trained in emergency medical treatment and handle all cases involving drunkenness that traditionally were handled by the police. One example of this is in Anchorage, where the police time spent dealing with drunkenness was reduced from 12.4% to 3.18% over the two and a half year period that the vans were in use. In Seattle, the emergency services unit of the county health department has replaced the police in picking up 12,000 public inebriates each year. In Sacramento, civilian vans picked up 2,900 public inebriates from the downtown area in the first half of 1979.

Some communities contract with ambulance services or use county medical teams to pick up public inebriates. In New York City, the Manhattan Bowery Project employs rescue teams composed of plainclothes police and recovering alcoholics. Donald McConnell, Director of the Connecticut Alcohol and Drug Abuse Council, reported that a taxi token system has been used in his state. A contract was established with a taxi firm to provide transportation for those drunk in public. Each trip where a taxi transports a public inebriate is billed by the taxi company to the state/county.

In rural areas that lack a sufficient number of clients to justify a full-time transportation system for public inebriates, alternative transportation methods must be developed. One such example is in the Portland, Oregon, area where volunteers are used to transport inebriates from a holding area in each rural jurisdiction to the detoxification center in downtown Portland.

Another option utilized in some communities is for police to transport inebriates to detoxification or shelter facilities. However, a study by Abt Associates points out that police may be reluctant to transport inebriates to treatment programs rather than jail for the following reasons:

★ It is not uncommon for police to resent their role as a transportation service for inebriates. This is especially true in rural areas where transportation to a treatment facility may be more inconvenient and time consuming than transportation to the local jail.

★ Handling of public inebriates and transporting them to a treatment facility does not normally count toward arrest totals or quotas, giving police officers little incentive to carry out this task. As a result, it appears that the police in many jurisdictions where decriminalization has been adopted, tend to ignore public inebriates as much as possible, thus perhaps depriving them of necessary care.

★ Police can circumvent decriminalization legislation by arresting public inebriates for other offenses, such as disorderly conduct and vagrancy, if they must assume the responsibility of transporting them to alcohol facilities.

Communities may use several approaches to help solve this problem. For example, the incentives for police to pick up public inebriates may be increased by simplifying the paperwork required for picking up intoxicated persons and delivering them to treatment facilities. In addition, jurisdictions may provide credit toward officers' arrest quotas for pickup and transport to treatment programs. Police officer cooperation may also be enhanced

through improved training. Training manuals covering ways of handling public inebriates, such as those developed by the International Association of Chiefs of Police, may be useful in this effort. Also, departments may establish information programs to apprise officers of the range and location of treatment facilities available. Finally, officers will be more responsive if they are made to feel that they are providing an invaluable service and given support by the treatment programs. For instance, one program makes coffee and a quiet office available to the police so they can take a break and/or complete reports.

Shelters

Shelters alone will not get at the underlying problems of the public inebriate or the causes of their drinking, but safe, clean and comfortable shelters are the first basic service that needs to be made available. These facilities are known as sleep offs, sobering up stations, or reception centers. These shelters provide supervised care, food, and clothing. Usually, they are located close to skid row areas and are open 24 hours a day or at least all evening (6:00 p.m. to 6:00 a.m.). A shelter that is located miles from skid row will not be used by inebriates.

Staffing for this type of facility usually includes several workers with at least one trained in emergency medical care in order to make an initial screening to refer those needing medical care. Often the staff will include nurses or medical interns. The key to the success of a shelter is that it be available to all who seek admission. A criteria may be established that requires the person be drunk, but most often these facilities are available to anyone in the community who is in need of shelter. Due to this facility being utilized by more than public inebriates, funding and staffing can often be obtained from the local general social service/welfare budgets.

One example of the effectiveness of shelter type programs is found in Denver. At the emergency service program, Denver CARES, 35% of those who enter the program only utilize shelter care and return frequently. However, 65% choose to go through detoxification and onto halfway houses and eventually break the revolving door pattern.

Day shelters are also found in many locations. Bean's Cafe, funded by the city of Anchorage, serves this function in that community. Bean's is a small cafe within two blocks of the skid row area with the primary purpose of providing meals to the homeless and street people of Anchorage. The facility is open from 5:00 a.m. to 6:00 p.m., providing three meals at a nominal charge.

We faced the fact that some of our public inebriates were not going to get sober, so we decided to settle for reducing suffering, and reducing costs.

—Donald J. McConnell,
Connecticut Alcohol and Drug Abuse Council

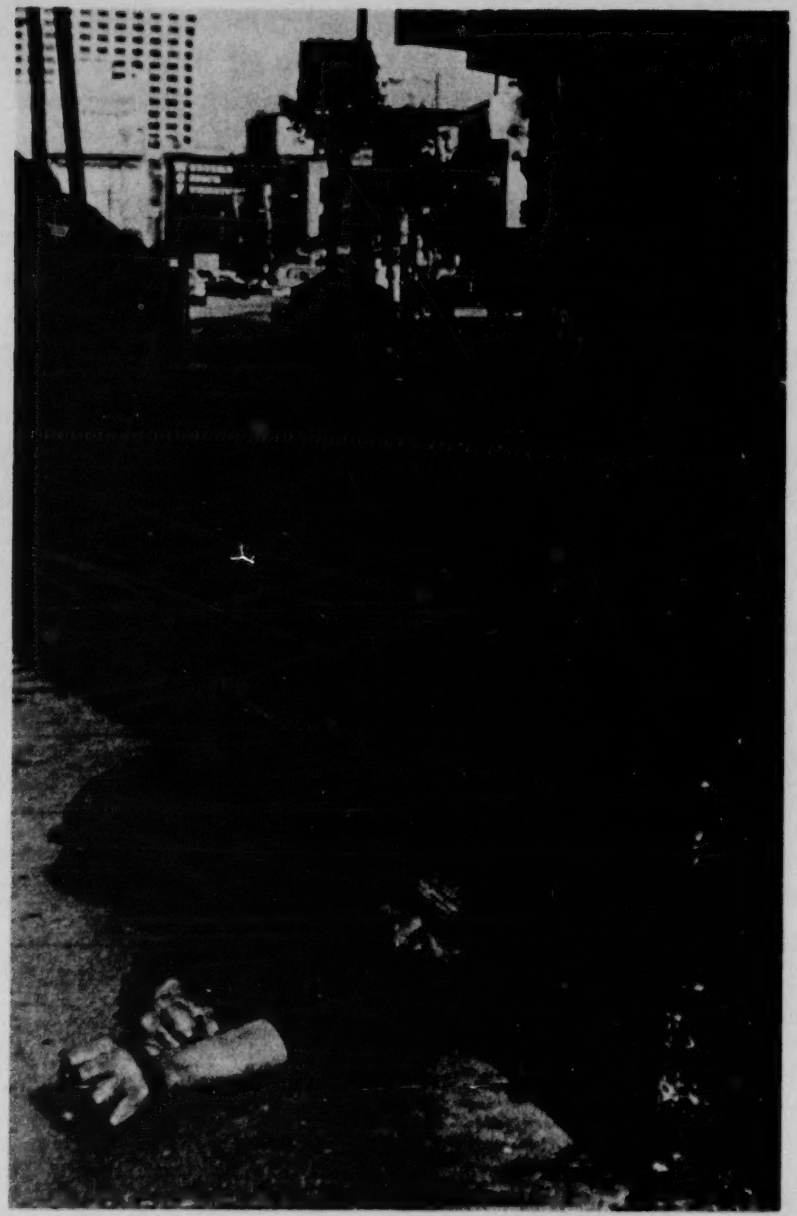
Recognizing that often the public inebriate will require long-term shelter, Connecticut has established an experimental facility for this purpose. This program has demonstrated a dramatic reduction in the costs of caring for public inebriates.

An approach to providing shelter in a rural area is found in Vermont, where volunteer families take in emergency cases for short periods until long-range treatment options can be developed. This program has been found to be very successful.

Another variation on the shelter theme is found in San Francisco. A park was created for those individuals who live on the streets around the "Tenderloin District." The area developed included benches, cement tubes for sleeping and protection from the weather, and rest rooms. The ideas behind the park was to offer public inebriates a place where they could sleep and congregate, yet be in a concentrated area away from the downtown businesses. To assure that the park served the needs of this population, several street people were consulted for their expertise prior to the actual development of the park.

There will always be public inebriates. Society is unlikely to find answers to this problem, and so perhaps our ambition should be to reduce the toll of human misery.

—Col. Harry Poole, Salvation Army



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Detoxification

Detoxification services must be made available in each community. The goal of detoxification is to safely assist the individual's withdrawal from alcohol. Most public inebriates are able to "sleep off" their intoxication without developing symptoms of the alcohol withdrawal syndrome. Others develop this syndrome to a mild degree. A small, but crucial group (either because of the severity of withdrawal or associated physical and mental problems) are at severe physical risk during their detoxification and require hospital care. Individual detoxification centers operate under the medical model, social setting model, or a combination of both. It is neither medically sound nor cost effective for a community to hospitalize all people who are intoxicated. Ninety percent of those detoxifying only need a social setting model to sober up. But communities do need a medical back up system for the other 10%.

There are still many medical model detoxification programs in the country which specialize in treating the alcohol withdrawal syndrome. Treatment is provided by physicians and nurses; drugs are routinely administered. These centers are often located in hospital or other medical facilities. During the detoxification period, counseling is provided in an effort to refer the patient for further treatment.

The Rapid City Regional Hospital in Pennington County, South Dakota, provides medical detoxification. Patients in need of detoxification are admitted through the emergency rooms whenever space is available. Treatment and care are provided by the regular hospital staff, most of whom have received in-service alcoholism training.

A recent development has been the creation of social setting detoxification programs. The main thrust of these programs is to provide a comfortable environment wherein the client can sober up. Emphasis is also placed on motivating clients to obtain treatment for their alcohol problems. Social setting detoxification programs do not provide medical care and thus are much cheaper to run. A procedure is usually set up for immediate referral to medical care for those patients for whom such care is indicated.

Many programs utilize a combination of the medical and social setting models. These are set up outside of a medical facility, yet are designed so that medical staff monitor the detoxification of all individuals in the facility.

New York State utilizes a three-pronged approach to detoxification. In some communities there are free standing social model detoxification programs; in others, detoxification is one aspect of a comprehensive treatment program; and in the third type (used in

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rural areas), detoxification is provided through a community general hospital. In the third type, the intoxicated individual is given a quick check by the hospital emergency room staff and is then assigned to a room adjacent to the emergency room for sobering up if hospitalization is not required. During the detoxification process, counseling and referral are offered.

Some communities contract for beds in nursing homes to be used for detoxification. And in rural areas, a regional approach is often used, where the detoxification center is located in one community and surrounding communities transport appropriate clients to the center.

Social model programs are considerably less costly than the pure medical model detoxification programs. In Los Angeles, California, the Volunteers of America program costs $30 a day, and the Talbot House, Catholic Charities of Amityville, New York, costs $40 a day. New York City's Manhattan Bowery social model program costs $45 a day compared to $80 a day for their medical model program. The medical program, however, is able to handle more serious cases.

Detoxification programs are usually set up as 3–5 day programs with an option for extended care, if necessary. These facilities have a dramatic effect on public intoxication arrests. For example, in Madison, Wisconsin, public inebriate arrests were reduced by 30% after a detoxification program was established.

Extended Care

In the ideal service system, once a client has completed detoxification, the next step is to move into extended care. The purpose of this phase of treatment is to stabilize the individual (physically, psychologically and socially), with emphasis on teaching social and coping skills so that successful integration back into the community as a sober individual may be achieved. The components of extended care are: inpatient care, residential treatment, halfway houses and aftercare/outpatient services.

Inpatient care is an extension of the detoxification process. The purpose is to maintain the client in a protective environment, so that the process of stabilizing emotional and physical conditions may continue. This treatment provides an environment where the client can begin to explore alternatives to drinking. Individual counseling and participation in information groups are often an integral part of this component and long-range treatment planning takes place at this time.

Another component of extended care is residential treatment. This phase averages four to sixteen weeks. The focus of treatment is on understanding one's problems and development of strategies for long-term sobriety. Therapy groups, individual counseling and attendance at Alcoholics Anonymous are essential ingredients. Other activities, such as work and/or recreational therapy, vocational rehabilitation, family counseling, and presentations to community groups are also included in the treatment program.

Halfway house facilities are the next step in the process once a client has demonstrated a desire to live a sober life and has developed skills to assist in this process. The main goals of these programs are to help the individual integrate back into the community. The client will live in the facility while at the same time hold a job in the community. Attendance at Alcoholics Anonymous meetings and other counseling is required. The aim is to offer a protected environment while the individual adjusts to the community as a sober individual. Quarterway, halfway and three-quarterway houses all fall into this category. The difference between these programs is directly linked to the amount of supervision and staff services provided.

Aftercare/outpatient care is available to the client once the residential phases have been completed. This component works to assure integration of the recovered alcoholic into the community and serves as a source of support. Weekly appointments are scheduled and then are gradually reduced until the client can function without the service. These aftercare components are the agencies to which the alcoholic can turn to for support after a relapse. Assistance in educational placement, job development and other such services are essential parts of this component. For example, in Seattle, a component of the aftercare program is a vocational resource center that follows the client for up to two years post treatment.

Domiciliary Care

Many chronic public inebriates, due to their age, years of poor nutrition and poor medical care, and deterioration as a result of excessive drinking, are unable to hold a job and care for themselves. Domiciliary care (long-term residences) are needed for these public inebriates, who will never be able to return to society as "productive" citizens. Minnesota has set up a series of domiciles known as Board and Lodgings. These converted houses serve as residences for six to ten debilitated alcoholics. They include a common living area and kitchen facilities, and an attempt is made to create a family atmosphere in the home. The staff consists of house parents who have knowledge of support programs available in the community for alcohlics. Each resident is required to pay for room and board from their welfare, Veterans Administration, social security or other benefits.

It is necessary to work with the citizens of the community where a domiciliary facility is to be located to ensure community support for the home. In several situations, after extensive community organizing, the residents of such facilities have been "adopted" by citizens in their respective neighborhoods. These types of facilities work particularly well in rural areas and in neighborhood communities within larger cities.

In downtown urban areas, efforts have been made to convert older hotels into domiciles for public inebriates. In many instances older hotels can be renovated and set up as service centers. Rooms, at minimum charge, are rented to inebriates, providing shelter off the streets. Staff are social service workers or are educated about the alcohol tretament resources available within the community. Thus, when a resident is ready for treatment, an appropriate referral can be made. In some facilities known as "wet hotels," individuals are allowed to drink in their rooms. The rationale for this is that if a person is going to drink, it is better to drink in the safe confines of one's residence than in the streets where one is prey for others.

The proposed "El Rey" project in Los Angeles will convert an old hotel into a comprehensive treatment center for public inebriates. The facility will handle 500 individuals a day on a shelter basis, 200 on an emergency only basis, and 100 in a detoxification program with an aftercare component. In Portland, Oregon, the Burnside Consortium, the agency responsible for public inebriate program operation and funding, is working to assist older hotels to find funds to renovate in order to meet health and safety codes. They realize that each hotel that closes will result in an increase of public inebriates on the streets of Portland.

Housing, Support, and Job Training

A long-term solution to the multi-faceted problems of a public inebriate depends upon his finding a job and housing. Without housing and a job, a return to the streets and to his old way of life is inevitable. Changing the environment in which he lives is a prerequisite to permanent change. Motivation to attain permanent sobriety is normally paired with a desire to be self supporting and improve oneself. Opportunities for such progress must be made available if stable rehabilitation is to be achieved.

Rehabilitation means more than treatment alone. The public inebriate requires a strong, coordinated response from many systems—health care, criminal justice, governmental, nongovernmental and the voluntary sector to deal with the problem of one of the most forgotten of our society's tragic victims.

—Gordon Steinhauer, Chairman of the Board,
National Council on Alcoholism

All the components outlined above as part of a system of care are not available in all communities. Each community needs to analyze which components of the system it needs and then develop a plan for obtaining the resources to meet the needs.

It is important to realize that the separate pieces of the continuum are not enough to facilitate the recovery of the public inebriate. A detoxification program alone will not help the public inebriate to remain sober. It must be part of a whole continuum of care. For example, in Broward County, Florida, services for the public inebriate began with just a detoxification program. Many people went through the program repeatedly. At a later date additional services were added so that a complete system of care was available. The result of the additional services was a marked reduction in recidivism among the public inebriates who participated in the full continuum.

A variety of services as well as coordination among the services are two factors which make a treatment system effective in dealing with the chronic public inebriate. The following are three examples of local service networks which provide a system of care for the public inebriate:

Division of Alcoholism, King County, Washington

In Seattle, the Division of Alcoholism serves unincorporated King County, the City of Seattle, and the 28 incorporated smaller cities within the county's boundaries. The 1980 Census set the county's population at just under 1,300,000. The County estimates that persons needing alcoholism treatment services in King County number 83,544. In 1968, the last year prior to decriminalization, there were approximately 12,000 arrests for being drunk in public. The program's philosophy is that alcoholism is a treatable disease and that recovery is possible through total abstinence; and finally, that participation in Alcoholics Anonymous is the most effective support program for the long-term recovery process. The range of services includes:

- **Emergency Services Patrol**—vans that patrol 24 hours a day and are staffed by Emergency Medical Technicians. Last year 13,079 public inebriates were picked up from the streets by the patrol.
- **Alcohol Screening Unit**—conducts medical examinations, recommends treatment, and initiates referrals.
- **Detoxification**—96-bed facility based on a modified-medical model.
- **Extended Care**—84-bed facility provides 30-day inpatient care in addition to a 44-bed facility that specializes in the care of Native Americans.
- **Vocational Resource Center**—provides a client advocacy service, employment assistance and follow-up.
- **Outpatient Clinics**—five Community Alcohol Centers, one located in each health district of the county. They provide the following services: outreach, diagnosis, outpatient and family counseling, court services, and work with the family.

Comprehensive Alcoholism Rehabilitation Program (CARP), West Palm Beach, Florida.

The CARP staff treats each admission as if he/she were a first time client, for this contact may be the one that leads to recovery. Emphasis is placed on working extensively with the community to ensure acceptance and support for the alcohol program. The continuum of care for public inebriates includes:

- **Receiving Center**—the primary focus is on stabilizing the physical needs of the inebriate and allowing him/her to sleep off the effects of the alcohol. The length of stay is usually under eight hours.
- **Primary Care**—detoxification services averaging 3–6 days utilizing a modified medical model with a nurse always on duty. Emphasis is on keeping the client quiet and anxiety free as stabilization is sought.
- **Treatment Planning and Motivation**—this is the crucial part of the continuum and provides in-depth data gathering and referral to continued care.
- **Extended Care**—this facility, Palm Beach Retreat, provides 4–8 weeks of residential treatment with emphasis on social stabilization, helping the client accept their alcoholism, and providing motivation for recovery.
- **Halfway Houses**—the CARP Program has two such facilities, both focusing on integrating the client back into the community. In both, clients must work, establish a bank account and attend Alcoholics Anonymous.
- **Domiciliary**—this is a long-term care facility for the chronic inebriate who cannot remain sober without this extended care.
- **Outpatient Services**—follow-up and community integration counseling and support.

Salvation Army

The Salvation Army is a religious and charitable, nonprofit organization with a long history of serving the urban public inebriate. One Salvation Army program, the Harbor Light Program, is a treatment approach for the public inebriate in several cities across the country. The program aids individuals in making the difficult transition from active alcoholism to a new, fulfilling and productive life of sobriety. The continuum of care for the public inebriate usually contains the following elements:

- **Phase I—Basic Admissions:** During the first 30 days the resident receives intensive counseling, a basic education in alcoholism and an introduction to Alcoholics Anonymous. During this period, the new resident is assigned daily tasks to strengthen his work habits, but is not allowed to accept employment, training, or school activities outside the house. An individualized program card is prepared to include a selection of regular and optional meetings and activities which will fill approximately 40 hours of time per week.
- **Phase II—Advanced Admissions:** During this period the resident begins to formulate a six months and one year balanced living plan with the assistance of the staff. The resident begins the design of a vocational plan and continues group and individual counseling activity. Various recreational, craft and socialization activities are provided.
- **Phase III—Preparation for Community Living:** At a point in time when the resident is able to begin part or full-time employment, his personalized activities schedule is redesigned to include evening program involvement. Activities are monitored by counselors to ensure that the resident maintains a balanced plan. At the conclusion of the third phase the resident is given assistance by a planning counselor in making the transition to community living.
- **Phase IV—Residence in a recovery home or other facility that is conducive to the maintenance of sobriety:** Emphasis is on offering an individual a safe environment to live while they work or go to school and fully adjust to a sober lifestyle back in the community.
- **Phase V—Follow-up services to individuals once all residential phases of the program have been completed.**

In the final analysis, it is people that are important. The dedication of good people can save lives, even if it cannot always change them.

—Col. Harry Poole, Salvation Army

Issues for Consideration

When a community begins to address the problems experienced and caused by public inebriates, several issues arise which need to be discussed and clarified before changes are implemented. For example, decriminalization was enacted in thirty-four states and territories for a multitude of reasons. Expectations of the effect of the enactments varied between and within communities. Some communities did not get the expected results and were disappointed. These disappointments could, perhaps, have been avoided if more discussion of assumptions held by decision-makers about the population addressed, problem definition, goals for the change, philosophy of intervention and extent of treatment, and expected funding costs and sources were held.

Population Definition and Problem Definition

The profile of the public inebriate nationally is of a 45-year-old white male, unemployed, unmarried and homeless. But many communities find that the profile of people called public inebriates in their community is different from the profile of a public inebriate in another community. It may be a younger person, or a mentally ill person who drinks. Once a community clarifies that target population, they need to define all aspects of the problem associated with that target group. Is the problem alcohol abuse, lack of medical care, lack of housing or jobs, poor physical condition, or a combination of some or all of these? Because the definition of the problem affects discussions about solutions, it is critical that community decision-makers clarify this point early in their efforts to change the public inebriate's situation.

Conflicting Goals in Decriminalizing Public Intoxication

In the public policy area, there are many goals that can be achieved by decriminalization—but some of these are in conflict with each other. (For a further discussion of these issues, see Aaronson, et. al., "Improving Police Discretion Rationality in Handling Public Inebriates.") Communities need to discuss the differing goals and set priorities among these. Different goals call for different systems to be established.

Some of the goals that a community may have are:

- ★ Saving criminal justice resources
- ★ Keeping the streets free of drunken people
- ★ Saving lives and providing humane emergency services to public inebriates
- ★ Rehabilitating the public inebriate
- ★ Clearing the streets of the non-inebriated people that the community does not want around (skid row and homeless people)
- ★ Changing the social environment which contributes to the emergence of the public inebriate

If the goal is to save criminal justice resources, then the handling of the public inebriate by the alcoholism treatment system suffices. But to fund the alcohol programs, money may have to be diverted from the criminal justice field or alcohol expenditures increased.

If the goal is to keep the streets free of drunken people, then extensive care facilities and a transportation system to pick up intoxicated people will have to be developed.

If the goal is to save lives and provide humane emergency services, then a detoxification program may suffice. San Francisco had a 54% drop in deaths from cirrhosis of the liver after opening their detoxification facilities. But the community must be prepared to accept a high rate of repeaters at the detoxification facility.

If we, as a society, truly care about our least attractive and most difficult to serve clients, then we will show it here, on the boweries and skid rows and in the 'impacted' areas of our nation.

—Sheila Blume, New York Division of Alcoholism

If the goal is to rehabilitate public inebriates, then a comprehensive system of care needs to be available and this means helping people make changes in their lives. It may be through just one person who takes an interest in another and supports him as he works to change, but usually, help is through a creative system of programs that are attractive to the public inebriate.

The needs of public inebriates are different and more complex than those of other alcoholics. Thus, traditional alcohol services based on middle class needs are not going to be effective with this population. Rather, one must develop services that will specifically meet the needs of the public inebriate. These services must also address the more complex social and environmental needs.

It is important that a community remember that extended care takes a long time, but can be a success if the person eventually leads a stable life with a stable income.

A testimony to the possibilities for change by a public inebriate is the example of Robert Sundance. Where he formerly spent an average of a third of each year in jail for being drunk in public, he now has been sober for five years, and is Executive Director of the Indian Alcoholism Commission of California.

The recovery of Robert Sundance, a chronic public inebriate, is a remarkable example of the ability of the human spirit to rebound.

—Timothy Flynn, Lawyer for Robert Sundance

If the goal is to clear the streets of people the community does not want around, then it may be more effective to confine these people (public inebriates and others) to a park and try to limit their access to the downtown section; or the city may provide a wet-hotel or a domiciliary as an alternative to living on the streets. Such facilities provide a place to sleep and eat and a sanctuary from the prey of others.

If the goal is to change the social environment which gives rise to and supports homeless people being drunk in public, then the community must bring housing, jobs, and health care to skid row. Many urban renewal projects have only made the problem worse, creating more homeless people, and turning their traditional areas into business districts whose new merchants complain about the homeless people there.

Until a community is clear about its goals and methods that will lead to those goals, public inebriates will continue to die in the streets and in the jails.

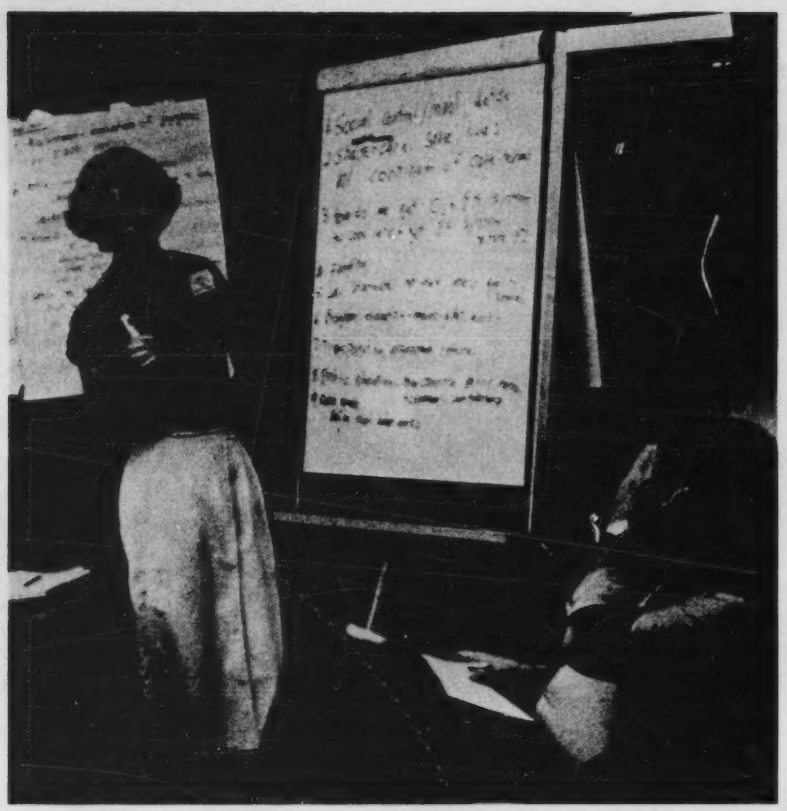
The revolving door justifies itself by keeping people alive.

—Sheila Blume, New York Division of Alcoholism

Intervention—To What Degree?

Different philosophies emerge when discussing if and when treatment should be given to the public inebriate. Some groups tend to romanticize the life of a homeless drifter by viewing skid row as the last vestige of the American frontier; or, thinking of the inebriate as a bold nonconformist in need of simple tolerance. This view of the public inebriate removes any sense of our responsibility to take action on behalf of those on skid row and makes one reluctant to intercede with their lifestyle. Irving Shandler points out that while it is all right to consider that some inebriates are not in need of our intervention, we must not retreat behind this into dangerous indifference, for there is real suffering on skid row.

Others argue that the true inebriate, because of the disease of alcoholism, has impaired judgment and rational decision-making abilities and, thus, is unable to make a choice about whether or not to seek treatment.



Still others, such as frustrated police and alcohol program staff who see the same people over and over again, may advocate the involuntary commitment of public inebriates as a way to force them to remain sober for a longer length of time and end the "revolving door." However, others feel that involuntary commitment is a violation of an individual's rights.

It is important to keep in mind, though, that many programs, such as that of the Manhattan Bowery, have found that when offered care, inebriated people on the streets will choose to go to a program—and many will choose to go on for further treatment. This demonstrates that if the program really meets the needs of the public inebriate, extended care can be a voluntary choice.

The above mentioned positions on the time and extent of intervention on behalf of the public inebriate naturally lead to different programs and objectives. Consequently, it is important that communities address these issues and reach agreement on the degree of intervention that is both sufficient and acceptable to them before they start developing programs.

The sober culture has a responsibility to interrupt irrationality.

—Irving Shandler, Diagnostic and Rehabilitation Center, Philadelphia

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Costs: Who and How Much?

Starting with the assumption that community budgets are always very tight, it is not surprising that when talking about the problems of the public inebriate and resulting effects on the community, there is considerable concern about costs. How much does it cost now to handle the public inebriate within the criminal justice system? How much will it cost to provide an alternative system? And, who will assume the expenses—the criminal justice system, the public health system, or diverse funding mechanisms initiated by the community?

Criminal justice costs vs. treatment costs. By decriminalizing public intoxication, a savings in the criminal justice system can be realized. Court and jail costs are substantially reduced and expensive police time is saved (though to a lesser degree, if they are still used to transport public inebriates to alcohol facilities).

The costs in 1981, in San Francisco, of arresting, transporting, booking, and adjudicating a person was $42.94. Those that were then sentenced to jail averaged $494.40 per person in additional costs. In Los Angeles, in 1976 (at the time of the Sundance Case), the cost to the city for arresting, booking, arraigning in court, and detaining in jail of one public inebriate was $232. With criminal justice costs very high, communities can often save money by handling the public inebriate outside of the criminal justice system. For example, in Los Angeles the comparative cost of arrest and 72 hours of detoxification in a treatment program (with an additional 15 days of care for 15% of the people) was $83.

The costs and responsibility for alternatives. The Uniform Act recommends that the public inebriate be removed from the criminal justice system, and that a system of alternatives be established to help this individual. Often, limited money is available for these alternatives, and yet the public health system is expected (but not prepared) to take over the problem. Although the public inebriate may be transferred from the criminal justice to the alcohol treatment system, the criminal justice funds previously spent on this individual are seldom transferred.

Communities may thus lose money when they first decriminalize and set up separate systems of care for the public inebriate, but in the long run they stand to save money. A statewide study conducted in Minnesota four years after the state decriminalized public intoxication found that the state's municipalities lost $443,310 annually in criminal fines that were no longer levied on public inebriates. But, they also found themselves spending between $7 and $8 million less annually in expenses for dealing with public intoxication in the criminal justice system. With jail space at a premium, construction costs skyrocketing, and the cost of housing a person in jail averaging $40 a day (without counting police and court costs), there is a lot of incentive for communities to find other ways of dealing with the public inebriate.

Potential funding mechanisms. Treatment agencies are being forced to find more creative mechanisms for funding public inebriate programs, as money from federal sources is reduced. Natural allies, such as police departments and merchants, are being tapped, and other new sources of funding are being explored. Funding a system of care is essential before further decriminalization will be successful.

Several programs have developed innovative funding approaches. One such program, Comprehensive Alcohol Rehabilitation Program (CARP), has created a client finance department which has two functions. The first is to assist clients in obtaining benefits for which the client is eligible. The staff of this unit is aggressive in working with welfare departments, Medicaid, Title XX, Blue Cross, and other providers, to make sure that the client's eligibility for the service is established. The second function is to impress upon the client their responsibility to pay for services rendered so that recovery can be provided to others. A payment plan is initiated after a client enters the program, and once employed, he is expected to start reimbursing the program for services rendered. The program has found that paying for treatment has increased the client's investment in the recovery process. In 1980, the finance department was able to generate approximately $200,000 in client fees, roughly 25% of the program's total budget.

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Another approach is to get local merchants who are concerned about public inebriates outside their establishments to request funds for services for this population from the city and county councils. In this instance, those with clout are being used as a means to approach governing bodies. Still another suggestion is to earmark a portion of the state tax on liquor to pay for public inebriate services. Other ideas put forth have been to tap Veterans Administration funds, special district funding, Housing and Urban Development funds, bar associations, unions, insurance companies and corporations for financing for public inebriate programs.

In-kind services, such as office space, equipment, or staff have been contributed by some government or private agencies. In one case, medical staff from the local health department were assigned to service the detoxification center. In another, an old school was converted to a comprehensive alcohol treatment program. In these instances, the staff and building were donated by the county.

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In sum, as with the goal and philosophical issues, communities must clarify the amount of money needed as well as who will have responsibility for funding solutions to the problems associated with the public inebriate.

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Summary

Public inebriacy remains a national problem, for it still accounts for well over a million arrests each year, millions of public dollars spent annually and thousands of needless deaths and shattered lives. Yet, despite these very serious consequences, government at all levels and, until recently, most segments of the alcoholism treatment community, have given the problem low priority.

The move to decriminalize public drunkenness, which finds its roots in the Driver, Easter and most recently, the Sundance Case, has been the major activity to help public inebriates in the Sixties and Seventies. Outside of the decriminalization movement, there has been no national policy or effort focused on this population. And, even in those jurisdictions where decriminalization has been implemented, the chronic public inebriate is underserved, inadequately cared for, and often detained in jails.

The problems remaining in spite of the decriminalization movement reflect the limitations inherent in a strategy overwhelmingly based on legislation and litigation. Public education, community action, and resource generation were seriously ignored. While program development seriously lagged, legal reforms created the false hope that this pattern of inhumanity and social injustice would soon be ended.

The need to end the practice of jailing public inebriates and to develop a more rational, effective, grassroots program for their care, were major themes that dominated the Wingspread Conference.

There was widespread consensus at the meeting that jailing chronic public inebriates is not only inhumane, but seriously aggravates the disease of alcoholism, and may lead to death or serious medical consequences.

The general strategy developed by the Conference participants included expanding the existing body of knowledge on the public inebriate; compiling and disseminating information on successful programs; and developing intergovernmental solutions to the problem.

Even though some of those at the conference questioned the motivation of chronic inebriates to utilize treatment, all agreed that the alcohol treatment system has not adequately focused on this population and that few communities offer a comprehensive range of services for the inebriate. It was questioned whether the treatment system has focused enough on this population to make services "attractive" to them.

There was general agreement on the following points:

★ All communities should have programs to serve the public inebriate.

★ Intervention in the life of the inebriate is appropriate where there is a threat to his or her life or to the lives of others.

★ Solutions to the public inebriate problem will require cooperation among many constituencies whose disparate interests and concerns must be considered.

★ Government, at all levels, has the responsibility to commit funds toward solving the problem.

The participants agreed that detoxification alone was not the answer and that a range of services needs to be provided. This sentiment was expressed by Vernon Ehlers, Board Chairman, Kent County, Michigan; "A detox revolving door can be more efficient and humane than a jail revolving door, but it doesn't solve the problem." David Couper, Chief of Police for Madison, Wisconsin, warned that without effective follow-up services, detox centers could emerge as a new type of jail, except that staff would be wearing "white coats."

Only a few states have even attempted to compare the potential savings in local criminal justice expenditures to the actual costs involved in providing a continuum of health and social services. One study in a state four years after it decriminalized public intoxication, compared only the costs of detoxification to criminal processing, leaving the implication that detox was all that was required.

In addition to cost saving arguments and the counterproductive practice of incarceration, recent court rulings have added other incentives for communities to end the practice of jailing public inebriates and to establish alternative treatment programs. Monetary judgments against local governments over the inadequate services and facilities for public inebriates in jail may result in the expansion of alternative treatment facilities.

The Conference participants, representing all levels of government and the private sector, developed an agenda for coordinated action on the national, state and local level. The action plan details what needs to be done on the issue of public inebriacy in the areas of funding, expanding knowledge, advocacy, interagency relations, information dissemination and training/technical assistance. Three principal areas of concern and suggestions for action highlighted by Conference participants were:

★ Better coordination and communication between criminal justice and health professionals to plan for the needs of the public inebriate and to educate city and county governments and the public on the problem and potential solutions to the problem.

★ A "How To" manual for communities who are attempting to deal with this issue. Model program descriptions, cost-benefit analyses, and information on solutions other communities have found effective should be included.

★ A national public inebriate specialist to help communities answer the many questions they have in attempting to deal with this problem.

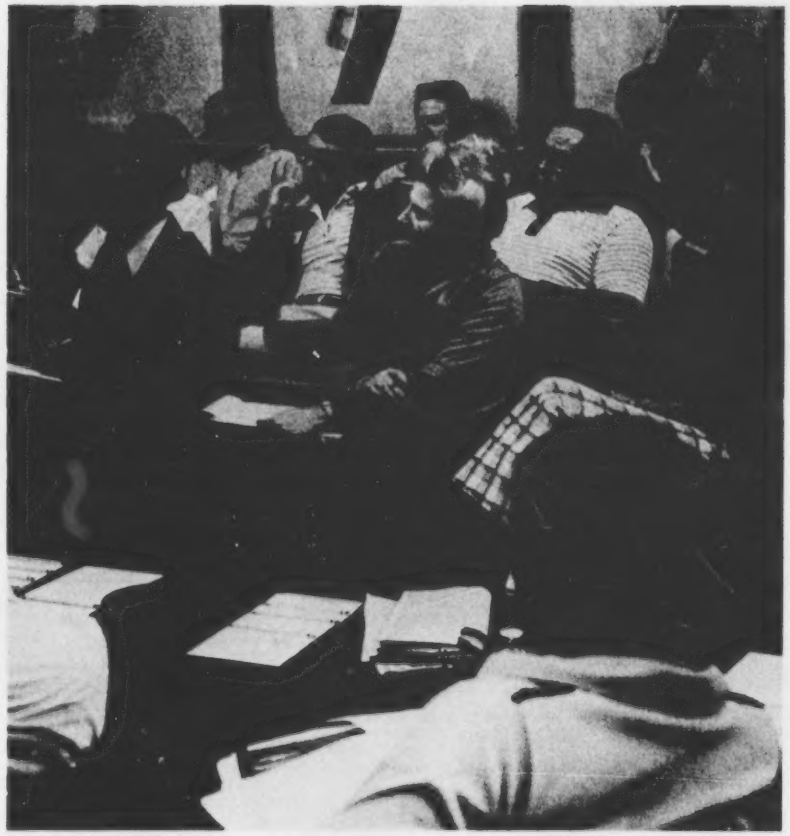
The entire action agenda developed by the Conference participants, outlining local, state and national activities, follows.

What Can Be Done on the Local Level?

The most effective action on any community problem comes at the local level. The state and federal government can support these efforts, but the initiative needs to come from the people who live in the community.

★ Conference participants recommended that cities and counties work more closely together. Cities have major responsibility for police, lockups, municipal courts and public housing; while counties, in addition to their criminal justice responsibilities, administer half the public assistance in the United States and most of the public health services at the local level.

It was recommended that city and county officials delineate roles and responsibilities and develop cost-sharing strategies in decriminalization efforts. Local jurisdictions also need to assess their liability exposure and experiences in relation to the jailing of public inebriates. By planning together, cities and counties can redistribute their resources to more effectively care for this population without putting undue strain on anyone.



★ It was recommended that comprehensive public inebriate programming be incorporated into the health planning process at the local level and that communities consider establishing interdisciplinary planning task forces to develop plans for helping public inebriates in their communities. Such a task force might include city and county elected officials; public housing, redevelopment and urban renewal agency officials; prosecutors; sheriffs; police; health professionals; church and civic representatives; business people; and personnel from the detoxification program.

★ Most public inebriate programs have been developed in the cities. Many public inebriates in rural areas end up in jail because the nearest program is too far away. There is a need for rural models to be developed and such existing programs publicized.

★ Criminal justice and health systems personnel need to see each other's problems. Historically, they have each tended to dismiss the problem of the public inebriate as being the other's concern. It would be productive to not only bring the practitioners in each field together, but to provide training for them on the special needs of this population.

★ Whether or not there are alcohol programs in the community, the police officer is often the first one to come in contact with the inebriated person. Some communities have worked with the police department to provide training for police officers on the issue of public inebriates and to obtain regular reports from police on the number of public inebriates they are picking up. At the officer's roll call at the beginning of each shift, information on the special needs of intoxicated persons and on community alternatives can be provided.

★ The public needs to be educated about the problems of public inebriates, the costs and ineffectiveness of jailing them and what alternatives are needed in the community. By working with service organizations, affiliates of the organizations within the National Coalition for Jail Reform, and alcohol organizations, public support for this can be generated. The support of the local media is crucial and they need to be involved from the very beginning.

What Can Be Done on the State Level?

★ A 1980 report by the General Accounting Office found that state alcoholism agencies had not paid sufficient attention to jail inmates with alcohol abusing problems and recommended that NIAAA revise its guidelines for state plans so as to encourage the assessment of jail inmate needs. The Wingspread conferees recommended that all state health plans contain a separate section on public inebriate services.

★ States can help local jurisdictions develop programs for public inebriates—not only through assisting in funding such services, but in providing technical assistance to local governments on how to develop comprehensive services for the public inebriate and encouraging interjurisdictional cooperation. States also need to explore the possibility of including the public inebriate under Title XX funding.

★ Statewide Coalitions can be effective in studying the problem, promoting model programs and cost-sharing strategies, and lobbying for legislation. Such Coalitions could also be helpful in planning multi-jurisdictional solutions in rural areas and in generating support for the Uniform Act in the 17 states which have yet to enact the law.

★ The conference participants agreed to encourage their state affiliates to incorporate information on public inebriate problems in their state in their publications and plans. The affiliates will be provided information about the problem by their national organizations.

★ There is a need for information on the public inebriate to be distributed to state planning agencies, and criminal justice, health and alcohol professionals. The Wingspread proceedings will be sent to state alcohol directors and other state officials.

What Can Be Done on the National Level?

★ The conferees recommended close collaboration with NIAAA in designing the first national study of the Uniform Act. No national study assessing the implementation of the Uniform Act has ever been completed. Since NIAAA does not require states to collect such data, it would appear that the federal government has not in the past based its incentive funding on any measurable performance, relying instead on a paper check or a content analysis of state legislation as opposed to any clear measure of compliance. There is a need to find out how many people are still in jail for public intoxication—whether under that charge, or under another charge, if the state has decriminalized. The need for such a study was stressed strongly by the conference participants.

★ The National Coalition for Jail Reform agreed to work with the National Institute of Justice and the Bureau of the Census on the 1982 jail census. Previous census studies, it was noted, failed to collect accurate data on the public inebriate problem.

★ The National Commission on Alcohol and Alcohol Related Problems will also be contacted to insure that public drunkenness is on the Commission's agenda.

★ All the organizations represented at the conference will develop policy on this issue and work to make it a priority in their future plans.

★ The Jail Coalition will work with those who are conducting other studies, to ensure that they produce information on public inebriate issues. The Police Executive Research Forum and the International Association of Chiefs of Police are collaborating on the first national study of city lockups, while the National Center on Institutions and Alternatives is undertaking a national assessment of suicides in jails and lockups.

★ The National Coalition for Jail Reform will attempt to locate funding to develop a manual to be utilized by communities attempting to deal with the problem. Conference participants stressed the need for such a manual which would contain a rationale for change as well as cost benefit comparisons and model program descriptions.

★ The participants agreed to work for passage of the Unifirm Act in the 17 states that have not adopted the Act.

★ National organizations at the conference and in the Jail Coalition will have workshops at their conferences on this issue to educate the members of their organizations.

★ There is a great need for a public inebriate specialist at NIAAA. Nowhere in the country is there just one person focused exclusively on this issue. To coordinate the activities of many separate individuals, programs, and organizations, to collect and distribute information, to provide assistance to communities and programs, to put out a newsletter—there needs to be one person with responsibility for public inebriate issues.

★ There is a pressing need to accurately identify the sub-cultural characteristics of this population group in order to understand their motivations and design effective strategies. The problems of the multiply-disabled—those with both alcohol and mental health problems—need to be addressed. There is a need for closer coordination with NIMH and state mental health directors to develop models for working with the public inebriate who has mental health problems. The Mental Health Act may contain provisions for services that cover this population. NIMH needs to be involved in the funding of such programs.

★ Conference participants recommended that NIAAA develop a public information document on the public inebriate and programs that are successful. There is also a need for a clearinghouse/newsletter on public inebriate issues.

★ The Jail Coalition will work with the National Clearinghouse on Alcohol Information to develop packaged materials on the public inebriate.

★ The conferees urged national criminal justice organizations to expand their training programs to include the problems of the public inebriate. Associations which represent such people as police, nurses, judges, doctors, and sheriffs and which already provide training, could incorporate information on the care of the intoxicated person into their training programs.

★ The Wingspread participants agreed to publicize this issue in the magazines and newsletters of the organizations represented at the conference, in alcohol magazines and in the mass media.

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Appendix

First National Conference on the Public Inebriate

Wingspread, Racine, Wisconsin
July 14–16, 1980

Speakers and Panelists

Speakers

Gordon L. Steinhauer
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Larry W. Monson
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National Association of State Alcohol and Drug Abuse Directors
Director
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Judith Johnson
Executive Director
National Coalition for Jail Reform

Panel: **Extent of the Problem**

Moderator: The Honorable Gary R. Goyke
State Senator
Wisconsin
Chairman, Council on Alcohol and Other Drug Abuse

Sheila B. Blume, M.D.
Director
New York Division of Alcoholism and Alcohol Abuse

Ray Daugherty
Executive Director
Kentucky Alcoholism Council/NCA

R. Page Hudson, M.D.
Chief Medical Examiner
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An Overview of the Problem

John M. McCabe
Legislative Director
National Conference of Commissioners on Uniform State Laws

Panel: **Assessing the Enactment and Results of the Uniform Act**

Moderator: John McCabe
Legislative Director
National Conference of Commissioners on Uniform State Laws

John DeLuca
Director
National Institute on Alcohol Abuse and Alcoholism

David C. Couper
Chief of Police
Madison, Wisconsin

Donald J. McConnell
Executive Director
Connecticut Alcohol and Drug Abuse Council

Panel: **Alternatives to Jail for the Public Inebriate**

Irving Shandler
President
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Philadelphia, Pennsylvania

Jim Cooks
Executive Director
Inner City Council on Alcoholism
Milwaukee, Wisconsin

Charles H. Kester
Manager
King County Division of Alcoholism Services
Seattle, Washington

Lt. Col. Harry W. Poole
National Consultant
The Salvation Army

Panel: **Dealing with the Problem: Policy Makers Respond**

Moderator: Gary F. Jenson
Executive Director
Governor's Council on Drug and Alcohol Abuse, Penn.

The Honorable Mike Ezzell
State Representative
Texas

Timothy A. Boggs
Professional Staff Member
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The Sundance Case

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Status of Decriminalization Legislation in States Which Have Not Enacted the Uniform Act (courtesy—NIAAA)

1. **Alabama**—Plans to introduce Uniform Act in the 1981 legislative session.
2. **Arkansas**—No legislative action currently planned.
3. **California**—Has legislation similar to Uniform Act, but decriminalization is by county option.
4. **Indiana**—Uniform Act was passed by legislature in 1977, but was vetoed by the Governor. No legislative action currently planned.
5. **Iowa**—Legislation similar to Uniform Act became effective 1/1/78, but decriminalization in accordance with the Uniform Act was not provided. No legislative action currently planned.
6. **Louisiana**—Uniform Act introduced in 1980 legislative session and passed but without provisions for decriminalization.
7. **Mississippi**—Has legislation similar to Uniform Act, but without decriminalization. No legislative action currently planned.
8. **Ohio**—Uniform Act introduced but did not pass in 1979 legislative session. SAA did receive increased State appropriations in 1979 and 1980. No current plans to reintroduce Uniform Act.
9. **Oklahoma**—Has legislation similar to Uniform Act, but without decriminalization. Uniform Act currently being discussed. Anticipate introduction in 1981 legislative session.
10. **Pennsylvania**—Bill has been introduced in 1981 legislative session, but chances of passage uncertain.
11. **South Carolina**—Uniform legislation passed and was to have become effective 7/77, but State Supreme Court ruled the Bill unconstitutional. No legislative action currently planned.
12. **Tennessee**—Uniform Act introduced and rejected several times. No immediate legislative action planned.
13. **Texas**—Uniform legislation introduced several times, but failed to pass due to lack of appropriations. Has been reintroduced in the 1981 legislative session.
14. **Utah**—Parts of the Uniform Act have been passed, but there are no provisions for decriminalization.
15. **Virginia**—Has legislation similar to Uniform Act, but without decriminalization. Has received funds for 2 pilot programs—one urban, and one rural—to demonstrate effects of decriminalization. The State Crime Commission is currently holding hearings around the State on the public inebriate—legislative action could result from the hearings.
16. **West Virginia**—Uniform legislation considered but rejected in the past. No legislative action currently planned, but a court case on cruel and unusual punishment is to be heard soon and its outcome may result in legislative action.
17. **Wyoming**—Uniform Act has been introduced in the 1981 legislative session, but may not pass due to large money bill attached.
18. **American Samoa**—Status unknown.
19. **Guam**—Uniform legislation introduced in 1978, but did not pass. Bill was revised and reintroduced in September 1979, and was expected to pass by end of calendar 1980.
20. **Northern Marianas**—Status unknown.
21. **Trust Territory**—Status uknown.

Uniform Act Implementation Grants: State Funding History

Special Grants		FY-75	FY-76	FY-77	FY-78	FY-79	FY-80
UNIFORM ACT		(16)	(21)	(25)	(29)	(32)	(34)
	TOTALS	**2,679,163**	**5,074,896**	**6,313,502**	**9,688,896**	**10,523,238**	**9,688,896**
1	Alabama						
2	Alaska	120,000	120,000	190,000	190,000	190,000	189,982
3	Arizona	150,901	156,637	263,275	263,275	263,275	261,794
4	Arkansas						
5	California						
6	Colorado	157,783	162,729	275,457	275,457	275,457	273,818
7	Connecticut		289,059	289,059	289,059	289,059	287,242
8	Delaware						189,982
9	District of Columbia	120,000	120,000	190,000	190,000	190,000	189,982
10	Florida	287,323	307,445	564,889	564,889	564,889	559,468
11	Georgia						
12	Hawaii			194,542	197,193	197,026	189,982
13	Idaho			195,279	195,279	195,279	194,687
14	Illinois		664,793	664,793	664,793	664,793	658,066
15	Indiana						
16	Iowa						
17	Kansas			263,538	263,538	263,538	262,055
18	Kentucky						
19	Louisiana						
20	Maine	128,051	130,507	211,013	211,013	211,013	210,216
21	Maryland	191,457	197,161	344,322	344,322	344,322	341,782
22	Massachusetts	230,388	240,576	431,152	431,152	431,152	427,478
23	Michigan				583,603	583,603	577,937
24	Minnesota	194,515	200,047	350,094	350,094	350,094	347,480
25	Mississippi						
26	Missouri				398,221	398,221	394,978
27	Montana		190,000	190,000	190,000	190,000	189,982
28	Nebraska					228,078	227,058
29	Nevada		190,000	190,000	190,000	190,000	189,982

30	New Hampshire						191,888
31	New Jersey			518,086	517,333	515,664	478,470
32	New Mexico				217,655	217,655	216,771
33	New York		980,922	1,059,279	1,063,321	1,054,655	970,064
34	North Carolina					453,506	449,540
35	North Dakota	120,000	120,000	190,000	190,000	190,000	189,982
36	Ohio						
37	Oklahoma						
38	Oregon	154,689	158,902	268,327	267,805	267,805	266,265
39	Pennsylvania						
40	Rhode Island	123,056	123,871	197,742	197,742	197,742	197,118
41	South Carolina						
42	South Dakota	120,000	120,000	190,000	190,000	190,000	189,982
43	Tennessee						
44	Texas						
45	Utah						
46	Vermont				190,000	190,000	189,982
47	Virginia						
48	Washington	180,998	186,754	332,571	329,169	332,295	321,240
49	West Virginia						
50	Wisconsin	211,773	219,542	389,084	389,084	389,084	385,960
51	Wyoming						
52	American Samoa						
53	Guam						
54	Puerto Rico	188,229	195,951	361,000	344,899	349,126	339,395
55	Trust Territory						
56	Virgin Islands					155,897	155,252

For Further Information on Public Inebriate Programs Mentioned Contact:

Beans Cafe
c/o Community Planning
Municipality of Anchorage
805 L Street
Anchorage, Alaska 95502

Broward County, Florida
Alcohol and Drug Abuse Services Division
1011 S.W. 2nd Court
Ft. Lauderdale, Florida 33312

Comprehensive Alcoholism Rehabilitation Program (CARP)
P.O. Box 2507
West Palm Beach, Florida 33402

Connecticut Alcohol and Drug Abuse Council
90 Washington Street
Hartford, Connecticut 06115

County Alcohol Program
San Francisco Department of Public Health
170 Fell Street
San Francisco, California 94102

Denver CARES
3840 York Street (Unit K)
Denver, Colorado 80205

New York State Division of Alcoholism and Alcohol Abuse
44 Holland Avenue
Albany, New York 12229

Kentucky Alcoholism Council
P.O. Box 868
Lexington, Kentucky 40587

King County Division of Alcoholism Services
1008 Smith Tower
Seattle, Washington 98104

Los Angeles Volunteers of America El Rey Project
c/o Timothy Flynn
Staff Attorney
Center for Law in the Public Interest
10203 Santa Monica Blvd.
Los Angeles, California 90067

Manhattan Bowery Corporation
8 East Third Street
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National Clearinghouse for Alcohol Information
1776 E. Jefferson Street—4th Floor
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Salvation Army Social Services
Central Region
860 W. Dearborn Street
Chicago, Illinois 60610

Salvation Army Soc Services
Eastern Region
120 W. 14th Street
New York, N.Y. 10011

Salvation Army Social Services
Southern Region
1424 N.E. Expressway
Atlanta, Georgia 30321

Salvation Army Social Services
Western Region
30840 Hawthorne Blvd.
Rancho Palos Verdes, California 90274

Conference Co-Sponsors

Jail Coalition

The National Coalition for Jail Reform is made up of 36 national groups that represent diverse interests. By pooling the knowledge, experiences and resources of its members, this unusual coalition is helping communities find solutions to major jail problems. The members of the Coalition all agree that the first step in reforming jails is to remove people who don't belong there. All 36 organizations agree that public inebriates, the mentally ill and mentally retarded, juveniles and many people held before trial do not need to be in jail. They are working together to help communities remove these people from jail and develop other alternatives where necessary. The members of the Coalition are:

- American Association for Ex-Offenders in Criminal Justice, Inc.
- American Association of Correctional Officers
- American Bar Association
- American Civil Liberties Union, National Prison Project
- American Correctional Association
- American Correctional Health Services Association
- American Friends Service Committee
- American Jail Association
- American Public Health Association
- Benedict Center for Criminal Justice
- Correctional Services Federation, U.S.A.
- Institute for Economic and Policy Studies, Inc.
- John Howard Association
- National Association of Blacks in Criminal Justice
- National Association of Counties
- National Association of Criminal Justice Planners
- National Center for State Courts
- National Council on Crime and Delinquency
- National Criminal Justice Association
- National Institute of Corrections
- National Interreligious Task Force on Criminal Justice
- National League of Cities
- National Legal Aid and Defender Association
- National Moratorium on Prison Construction
- National Sheriff's Association
- National Street Law Institute
- National Urban League
- Offender Aid and Restoration of the United States, Inc.
- Police Executive Research Forum
- Pretrial Services Resource Center
- Southern Coalition on Jails and Prisons
- Unitarian Universalist Service Committee

Affiliates

- Citizen Advocates for Justice, Inc.
- National Center for Youth Law
- Pennsylvania Prison Society
- Police Foundation

NASADAD

The National Association of State Alcohol and Drug Abuse Directors, Inc., is a not-for-profit corporation, chartered in November, 1971, whose membership is made up exclusively of the official state alcohol and drug abuse authorities of the fifty states. The goals of NASADAD are:

★ To foster the development of a comprehensive alcohol and drug abuse program capability in each state;

★ To facilitate the evaluation, dissemination, and inter-state exchange of alcohol and drug abuse information and program activities among the State program administrators;

★ To assist the Federal and State governments in the design, development and implementation of coordinated, cooperative Federal-State programs;

★ To encourage the Federal government to engage with the States in the comprehensive planning and utilization of government resources at all levels;

★ To identify common interests and differences among the States in the nature of their alcohol and drug problems and to assist in the design of programs tailored to local characteristics;

★ To identify problems and issues that require study and research, as well as to conduct evaluation activities upon the request of the State alcohol or drug abuse coordinators.

NCA

The National Council on Alcoholism, Inc., founded in 1944, is the only national voluntary health agency founded to combat the disease of alcoholism. The Council's major areas of activity are medical, labor-management, prevention and education, public information, publications, research and evaluation, community services, women, youth, the family, and minority affairs.

NCA has 223 local and 15 state voluntary alcoholism association affiliates. The American Medical Society of Alcoholism, the Research Society on Alcoholism and the National Nurses Society on Alcoholism are all components of NCA.

Some of the goals of NCA are:

★ To assure nationwide public awareness of alcoholism and alcohol abuse as a major health problem, to create community support for programs to deal with alcoholism and to advocate national, state, and community support for voluntary movements in the alcoholism field.

★ To represent to Congress, the Executive Branch, and other national organizations the interests and concerns of private citizens on issues of public policy and social concern affecting the prevention and control of alcoholism; to act as a catalyst to local NCA affiliates to promote and support efforts to impact alcoholism public policy at local, state, and federal levels.

★ To promote and encourage widely accessible quality treatment and service within local communities, and to provide referral to treatment of alcoholic people and their families.

★ To insure that medical and related health professions are organized for and directed toward the effective prevention, diagnosis, early intervention, and treatment of alcohol abuse and alcoholism, and to encourage maximum involvement of all health professions in the alcoholism field.

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